

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>393053</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>05/24/2023</b>
NAME OF PROVIDER OR SUPPLIER: <b>PENN STATE HEALTH REHABILITATION HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>1135 OLD WEST CHOCOLATE AVE HUMMELSTOWN, PA 17036</b>		
STATE LICENSE NUMBER: <b>21700101</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 0000	INITIAL COMMENT  This report is the result of an unannounced onsite complaint investigation CHL23C095H completed on May 24, 2023, at Penn State Health Rehabilitation Hospital. It was determined that the facility was in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Hospitals, 28 PA Code, Part IV, Subparts A and B, November 1987, as amended June 1998.	P 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:



# Certified End Page

**PENN STATE HEALTH REHABILITATION HOSPITAL**

**STATE LICENSE NUMBER: 21700101**

**SURVEY EXIT DATE: 05/24/2023**

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

Handwritten signature of Jeane Parisi in black ink.

*Jeane Parisi*  
*Deputy Secretary for Quality Assurance*

Handwritten signature of Debra L. Bogen MD in black ink.

*Debra L. Bogen, MD, FAAP*  
*Acting Secretary of Health*



THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY